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Issue Date: 12 July 2006

CASE NO.: 2005-LHC-569
OWCP NO.: 06-190870

In the Matter of:

JAMES R. BALL,

Claimant,

v.

LOGISTEC, INC.,

Employer,

and

SIGNAL MUTUAL INDEMNITY ASSN. LTD.,

Carrier.

Appearances:

William H. Yanger, Esq.
For the Claimant

Richard P. Salloum, Esq.
For the Employer

Before: Stephen L. Purcell
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim under the Longshore and Harbor Workers' Compensation Act ("Act" or "LHWCA"), 33 U.S.C. § 901 *et seq*. James R. Ball ("Claimant") is seeking compensation and medical benefits for alleged work-related injuries to Claimant's neck

and back, as well as headaches and mental disorders, which he claims left him disabled. Claimant's Pretrial Statement; ALJX 4.[1]

A formal hearing was held in this case on June 9, 2005 in Tampa, Florida at which both parties were afforded a full opportunity to present evidence and argument as provided by law and applicable regulations. Claimant offered exhibits 1 through 5, which were admitted into evidence. Employer offered exhibits 1 through 77, which were admitted into evidence. ALJX 1 through 4 were marked for identification and admitted into evidence without objection.[2] Both parties filed post-hearing briefs. The findings and conclusions which follow are based on a complete review of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent precedent.

I. STIPULATIONS

The parties have stipulated (ALJX 4) and I find:

1. The date and location of the injuries alleged by Claimant are March 26, 2003 in Port Manatee, Florida.
2. Claimant has alleged that he sustained injuries on that date to his head, neck and back when he was struck on the top of his head by a sea clamp attached to a ship's wench.
3. The parties are subject to the Act.
4. Claimant and Employer were in an employee-employer relationship at all relevant times.
5. Any injury sustained by Claimant on March 26, 2003 occurred within the course and scope of employment.
6. Employer was timely notified of the injury.
7. Claimant filed a timely claim.
8. Employer filed a timely first report of injury and notice of controversion.
9. Authorized, accident-related medical benefits were paid under Section 7 of the Act.
10. Employer paid Claimant temporary total disability benefits from March 27, 2003 to June 2, 2003 and from August 4, 2003 to September 14, 2003.
11. Claimant's average weekly wage ("AWW") at the time of his injury was $571.33, yielding a compensation rate of $380.88.

[1] The following abbreviations will be used as citations to the record: "CX" for Claimant's Exhibits, "EX" for Employer's Exhibits, "ALJX" for Administrative Law Judge Exhibits, and "Tr." for Transcript.

[2] The pretrial stipulations of the parties were designated as ALJX 4 at the hearing. Tr. 5. However, they were inadvertently mislabeled as "ALJX 3." Any reference to "ALJX 4" in this decision is meant to refer to the pretrial stipulations. The pretrial statement of Employer is designated ALJX 3.

II. ISSUES

The following unresolved issues were presented by the parties (ALJX 4):

1. Whether Claimant sustained an injury as a result of his March 26, 2003 accident?
2. Whether any injury suffered by Claimant as a result of his March 26, 2003 accident resulted in disability?
3. Whether Employer is obligated to pay for medical expenses over and above those it has already paid?

III. STATEMENT OF THE CASE

Testimonial and Non-Medical Evidence

1. Testimony of James R. Ball

Claimant testified at the formal hearing on June 9, 2005 that he was born December 25, 1946 in Augusta Georgia, graduated from high school, and began working as a longshoreman in 1966. Tr. 20. He has been married for four years to Nadine Ball, but they lived together for 20 years before that. *Ibid*.

Mr. Ball testified that he was injured on March 26, 2003 while working for Logistec when he was stuck by a "sea clamp."[3] Tr. 21. Claimant stated that he was working in the ship's hold when the sea clamp struck him in the head and knocked him unconscious. Tr. 22. He further testified that his neck, shoulder and back were "killing" him after the accident. *Ibid*. According to Claimant, he subsequently learned that he was taken by helicopter to the hospital after the accident. Tr. 22-23. Mr. Ball also testified that he cannot hear anything on his right side since the accident. Tr. 25. He acknowledged that he had hearing problems before his accident, and stated that he had undergone an operation, but testified that his hearing had gotten worse since the accident. Tr. 25-26.

Mr. Ball stated that he was treated by Drs. Martinez and Inga after his accident, and that at the time Dr. Martinez told him he could return to work, he could "hardly hold [his] head up. Tr. 26. According to Claimant, his neck hurt at that time and was "popping." *Id.* He did not believe he could return to work because he could not physically perform the duties of his job. Tr. 27. Claimant testified that he had problems turning and looking up, and his lower back hurt. *Id.* He also testified that he did not have these problems before the accident. *Id.* According to Claimant, he was fully capable of performing his duties as a longshoreman before his March 26, 2003 accident. *Id.* He further testified that, as of the time of the hearing, he remained incapable of performing his prior duties. Tr. 28.

[3] He explained that a sea clamp (also sometimes referred to as a "C-clamp") is a "big old iron thing" which weighs about 3,000 pounds and is used to move pallets of materials out of the hold of the ship. Tr. 23. A series of five photographs, marked as CX-4 A through E, depict sea clamps from various angles. Each sea clamp has a series of 3 sets of "prongs," like those on a forklift, which are inserted into pallets laden with cargo, and are hoisted onto and off ships via a wench during the loading and unloading process.

Claimant acknowledged that he was referred to Drs. Joseph Rashkin and Conrad Weller by his attorney. Tr. 28. He testified that he received treatment for headaches. *Ibid*.

On cross-examination, Claimant testified that he is a member of ILA Local Union 1759 and has held a commercial driver's license for at least the last ten years which allows him to drive trucks up to 72,000 pounds. Tr. 29-30. His main job as a longshoreman is as a forklift operator, and where he works at Port Manatee depends on where the ILA union sends him. Tr. 30-31. He testified that he previously injured his ankle while working as a forklift operator in April 1988 for Federal Marine Terminal, and he filed a claim for that injury. Tr. 31. Claimant also filed a claim for a 1999 hand injury. Tr. 32. He testified that he also hurt his fingers in 2002 while working for Harborside Refrigeration stevedoring company, and had filed claims against them relating to injuries on June 17, 2002, August 20, 2002 and October 21, 2002. Tr. 32-33. Claimant acknowledged that Dr. Farrior previously treated him for chronic ear infections in both ears, performed two surgeries on his left ear, prescribed hearing aids for both ears, and was deposed by Employer's counsel in connection with Claimant's 1999 claim against Federal Marine Terminals. Tr. 33-34. He also acknowledged that he has worn a hearing aid in each ear for several years, including before his accident with Logistec. Tr. 35.

At the time of Claimant's March 26, 2003 injury, he was working as a longshore forklift operator. Tr. 37. He stated that he was operating a forklift in the hold of the ship when the injury occurred. *Id.* Claimant testified that he was wearing a hard hat at the time of the injury. *Id.* He was discharging a Del Monte fresh fruit ship. Tr. 38. Claimant stated that his main job as a forklift driver was to handle incoming fresh fruit. Tr. 39. He testified that on the day he was injured, he was operating an electronic forklift that had an automatic transmission and power steering. Tr. 39-40. The accident occurred in the late afternoon of March 26, 2003. Tr. 40.

Claimant testified that he was initially represented in this matter by Attorney Robert Chadwick, and that Mr. Chadwick recommended Dr. Robert Martinez as his treating physician. Tr. 41. He also stated that he has not been hospitalized since his release from Bayfront Medical Center on March 26, 2003. Tr. 42. Claimant testified that he fired Mr. Chadwick on November 25, 2003 and retained his current attorney, William Yanger, on December 4, 2003. Tr. 42. Mr. Yanger subsequently sent him to a psychiatrist, Dr. Weller, and an anesthesiologist, Dr. Rashkin. Tr. 42-43. He did not seek permission from either the Department of Labor or Employer prior to being seen by Drs. Weller and Rashkin. Tr. 43. Claimant's attorney paid Dr. Weller $1,400 and Dr. Rashkin $1,000 for their services to Claimant. *Ibid*.

Claimant acknowledged that he was involved in a prior motor vehicle accident long before his March 26, 2003 accident in which he claimed he had sustained a whiplash injury to his neck. Tr. 43. He further testified that he has not worked or sought employment since March 26, 2003 because he has not been able to work. Tr. 44-45. Claimant testified that he has updated his union card since the time of the accident. Tr. 45.

On redirect examination, Claimant stated that, since the accident, he could not drive a truck, do concrete finishing, or work as a forklift driver. Tr. 45-46. He also testified that he has developed memory problems since his accident. Tr. 45. Claimant stated that his duties as a forklift driver included some physical labor, such as stacking boxes. Tr. 46.

Medical Evidence

1. Medical Reports and Deposition Testimony of Dr. Robert Martinez

Dr. Martinez wrote numerous medical reports and gave a deposition. EX 25; EX 27; EX 28; EX 31; EX 74. He examined Claimant on April 23, 2003. EX 25. Claimant's chief complaints were headaches, neck pain, and low back pain. *Id.* at 1. Claimant reported that a spreader bar, weighing approximately 3,000 pounds, hit him on top of his head, knocking him unconscious and throwing him to the ground. *Id.* He was wearing a hard hat at the time. *Id.* He was taken by helicopter to Bay Front Medical Center. *Id.* Dr. Martinez stated that while in the hospital, Claimant had a CAT scan of his brain that was "apparently normal" and a CAT scan of his neck that "demonstrated some severe degenerative arthritis." *Id.*

Claimant complained of chronic headaches, generalized in nature, consisting of severe pressure in his head, occurring on a daily basis. *Id.* He also stated that he had constant sharp neck pain, involving the muscles of the neck, shoulders, and upper back. *Id.* Claimant also noted sharp lower back pain and back stiffness. *Id.* at 2.

On physical examination of the cervical spine, Dr. Martinez found tenderness over the C4-C5 vertebrae and mild muscle spasm. *Id.* at 3. He further found tenderness, swelling, and muscle spasm in the thoracic spine, with 3 cm nodules. *Id.* at 3-4. Also, Dr. Martinez noted diffuse tenderness, swelling, and nodular muscle spasm in the lumbar spine between L1 and L5. *Id.* at 4. Dr. Martinez also conducted a neurological examination which was normal. *Id.*

Dr. Martinez concluded based on his examination that Claimant needed MRI scans of his spine and brain. *Id.* at 5. He restricted Claimant's physical activity, recommending no jumping or bouncing exercises and no lifting of greater than 20 pounds from a bent position. *Id.* Dr. Martinez opined that Claimant's symptoms resulted from the blow to his head on March 26, 2003. *Id.* at 6.

Dr. Martinez examined Claimant again on May 12, 2003. EX 27. He reviewed the medical records of Dr. Tom Newman. *Id.* at 1. Dr. Martinez stated that the MRI of Claimant's brain was normal. *Id.* He opined that the MRI of Claimant's cervical spine demonstrated multiple level disk degeneration and bulging with protrusion at C3-4. *Id.* Dr. Martinez noted that these appeared to be pre-existing degenerative changes. *Id.* An MRI of Claimant's lumbar spine demonstrated multiple level degenerative changes at L4-5 with a bulging disk. *Id.* Dr. Martinez opined that Claimant had probable degenerative arthritis of the cervical, thoracic, and lumbar spine. *Id.* at 2.

Dr. Martinez examined Claimant again on June 11, 2003. EX 28. He reviewed the medical records of Dr. Tom Newman. *Id.* at 1. Dr. Newman opined that Claimant had reached maximum medical improvement with no evidence of permanent injury. *Id.* Dr. Newman also released Claimant for regular work with no restrictions from a neurological point of view. *Id.* Dr. Martinez agreed with Dr. Newman's assessments. *Id.* He again reviewed the MRI scans

from his previous report and concluded that Claimant had no evidence of an any injury, could return to full-time, regular work with no restrictions, and had a 0% impairment rating. *Id.*

Dr. Martinez examined Claimant again on June 15, 2004. EX 31. He reviewed the medical records of Drs. Inga, Newman, and Rashkin. *Id.* at 1. Dr. Martinez opined that Claimant had pre-existing degenerative arthritis. *Id.* He stated that Claimant's complaints of soreness and stiffness in the back of the head, neck and back were consistent with symptomatic degenerative arthritis. *Id.* Dr. Martinez noted that Claimant reported tenderness in the cervical, thoracic, and lumbar spine without muscle spasm. *Id.* at 2. He stated that Claimant had full range of motion of the cervical and lumbar spine. *Id.* at 3. Dr. Martinez also noted that Claimant had hearing loss. *Id.* at 4.

Dr. Martinez gave a deposition on May 31, 2005 in which he reiterated his findings and conclusions. EX 74. He further testified that he has been a neurologist for 26 years in private practice and became board-certified by the American Academy of Neurology and Psychiatry in 1980-1981. *Id.* at 4.

2. Medical Reports and Deposition Testimony of Dr. Thomas M. Newman

Dr. Newman wrote numerous medical reports and gave a deposition. EX 33-40; EX 75. He examined Claimant on April 21, 2003. EX 33. Dr. Newman took Claimant's accident history, noting that Claimant was struck in the head by a sea clamp. *Id.* at 1. He reviewed the hospital records, noting that the x-rays of the lumbar spine and CAT scan of the cervical spine and brain were "unremarkable." *Id.* Dr. Newman noted that Claimant complained of persistent headaches with memory loss, neck pain, and lower back pain. *Id.* He stated that he saw Claimant in 2002 in connection with a previous head injury. *Id.* Dr. Newman's evaluation at that time was unremarkable. *Id.* As a result of his examination, Dr. Newman recommended an Electroencephalogram ("EEG") for Claimant's head and MRI scans of his cervical and lumbar spine. *Id.* at 3.

Dr. Newman conducted MRI examinations of Claimant's lumbar spine and cervical spine. EX 34; EX 35; EX 37. The MRI on Claimant's lumbar spine was normal except for the L4-5 discs. EX 34. Dr. Newman found disc degeneration and broad-based disc bulging, as well as bilateral foraminal narrowing and facet arthropathy. *Id.* at 1. The MRI, conducted April 25, 2003, on Claimant's cervical spine was normal except for the C3-4, C4-5 and C5-6 discs. EX 35. The C3-4 disc showed a small central disc protrusion without lateral nerve root impingement. *Id.* Dr. Newman stated that, with regard to the C4-5 and C5-6 discs, "these levels show disc protrusion without lateral nerve root impingement." Dr. Newman conducted more MRI scans on May 5, 2003. EX 37. He stated that the MRIs of Claimant's cervical spine and lumbar spine showed some degenerative changes but otherwise were unremarkable. *Id.* at 1. Dr. Newman concluded that Claimant could "resume light duty work with a lifting restriction of 10-20 lbs." *Id.*

The EEG impression of Claimant's head, taken on April 29, 2003 by Dr. Newman, was normal. EX 36. He conducted another EEG on May 5, 2003 and also concluded that it was normal. EX 37. Dr. Newman conducted a follow-up evaluation on June 2, 2003. EX 39. He

stated that Claimant complained of persistent headaches and said he had some memory loss. A CAT scan of Claimant's brain, taken at the time of his injury, as well as an EEG, were normal. *Id.* at 1. Dr. Newman concluded that Claimant could resume normal work without any specific restrictions. *Id.* He wrote an addendum to the report in which he noted that an MRI scan of Claimant's brain, taken April 25, 2003, was normal. *Id.* In the addendum, Dr. Newman also opined that Claimant had reached maximum medical improvement with no evidence of permanent injury. *Id.*

Dr. Newman gave a deposition on May 31, 2005 in which he reiterated the findings and conclusions in his reports of examinations. EX 75. He testified, *inter alia*, that he has been board-certified in neurology since 1980. *Id.* at 4.

3. Medical Report of Dr. Steven J. Tresser

Dr. Tresser examined medical records with respect to Claimant on October 21, 2003. EX 43. He reviewed an MRI scan and x-rays of Claimant, conducted August 12, 2003. *Id.* Dr. Tresser opined that the MRI scan and x-rays demonstrated degenerative changes in the cervical spine with spondylosis at C5-6 and a superimposed central bulge at C5-6, which did not appear to be surgical in nature. *Id.* He stated that the bulging disc appeared to be "entirely degenerative in origin consistent with a mid 50-year-old gentleman." *Id.* Dr. Tresser stated that he could not comment on work restrictions because he did not examine Claimant. *Id.* He opined that Claimant did not have a permanent injury. *Id.*

4. Deposition Testimony of Dr. Joseph Rashkin

Dr. Rashkin gave a deposition on May 10, 2005. CX 1. He testified that he is board-certified in anesthesia and chronic pain management.[4] *Id.* at 3. Dr. Rashkin further testified that when he examined Claimant in February 2004,[5] he also reviewed medical records from treating physicians, including Dr. Martinez, Dr. Newman, Dr. Jorge Inga, and some medical records form Bayfront Hospital. *Id.* at 7.

Dr. Rashkin took a history from Claimant noting that he was a longshoreman, and that while he was working, the prongs of a forklift dropped on his head, knocking him unconscious. *Id.* Claimant described pain in the back of his neck that radiated into the right shoulder, right scapula, upper chest, and shoulder blade in the back. *Id.* He also complained of headaches to the right side of the frontal part of his head. *Id.* at 8. Claimant noted hearing loss on the right side, such that he needed an amplifier to be able to hear. *Id.* Claimant complained of low back pain that radiated into both of the hip regions. *Id.*

Dr. Rashkin conducted a physical examination of Claimant. *Id.* at 10. In examining Claimant's cervical spine, Dr. Rashkin found that Claimant was tender in the neck, mostly on the right side, as well as at the base of the skull. *Id.* He also examined Claimant's lumbar spine,

[4] His curriculum vitae, submitted as Exhibit 1 to CX 1, reflects that he has been board-certified as an anesthesiologist since April 1990.

[5] A copy of Dr. Rashkin's report of his February 24, 2004 Independent Medical Examination of Claimant is attached to his deposition as Exhibit 2.

finding tenderness over the sacroiliac areas. *Id.* He stated that the movements of the lumbar spine, such as extension and side flexion, caused aggravation of the discomfort in Claimant's low back. *Id.* Dr. Rashkin found no abnormalities in the extremities. *Id.* at 11.

He opined that Claimant had chronic neck pain, due to disc disease in the neck, causing irritation of the cervical nerves that come out of the neck. *Id.* He suggested that the disease was not a preexisting condition. *Id.* at 12. Dr. Rashkin opined that even if Claimant did have a preexisting condition, being hit in the head by the forklift aggravated that condition. *Id.* He also stated that Claimant had occipital cephalgia, an irritation of the nerves that came out of the base of the skull, on both sides. *Id.* at 12-13. Dr. Rashkin noted that Claimant's chronic lower back pain was due to disc disease and lumbar facet mediation. *Id.* at 13.

Dr. Rashkin explained that facets are joints in the lumbar spine where the lumbar bodies hinge together. *Id.* He further noted that mediated lower back pain occurs when the tendons that hold the joints together are damaged, ripped or pulled. *Id.* Inflammation is also possible. *Id.*

Based on his examination, Dr. Rashkin opined that Claimant should take anti-inflammatory medication, a muscle relaxant, and a trial of more invasive types of treatment. *Id.* at 15. He further opined there was "a pretty good possibility" that Claimant's March 26, 2003 accident was a cause of Claimant's chronic neck pain with radiculopathy distribution on the right. *Id.* at 16. Dr. Rashkin stated that Claimant's occipital cephalgia and chronic lower back pain were caused by the accident. *Id.* at 17.

Dr. Rashkin opined that Claimant was temporarily, totally disabled and should not be working. *Id.* He stated that Claimant could not perform heavy, medium, light, or sedentary work. *Id.* at 17-18. Dr. Rashkin also placed restrictions on Claimant that Claimant should not lift greater than 10 pounds repetitively, should not be in a cold, closed environment, and should not do any crawling, squatting, bending, or any activity involving his cervical or lumbar spine. *Id.* at 18. He opined that Claimant had not reached maximum medical improvement and that Claimant required medical treatment, including chronic pain management. *Id.* at 19.

On cross-examination, Dr. Rashkin was asked about a February 13, 2004 letter sent to him from Attorney William Yanger's office. *Id.* at 21. He confirmed that the letter stated that he had been paid $1,000 in advance to evaluate Claimant and that the letter gave Claimant's history. *Id.* at 22. Dr. Rashkin estimated that he saw approximately ten of Mr. Yanger's clients in the three or four years prior. *Id.* at 23. Over the same period of time, he estimated that he gave between five and fifteen depositions for Mr. Yanger's clients. *Id.* at 25.

Dr. Rashkin was asked about his examination of Claimant, which occurred on February 24, 2004. He stated that he did not assign any restrictions on activity at that time. *Id.* at 30. Dr. Rashkin acknowledged that the first time he mentioned restrictions on Claimant's activity was at the deposition. *Id.* He stated that he was unaware that Dr. Farrior, an ear specialist, had treated Claimant in the past. *Id.* at 31.

Dr. Rashkin agreed that when Claimant performed a "straight leg raising" test, the result was normal. *Id.* at 32. He stated that generally, this result is inconsistent with nerve root

compression. *Id.* He also agreed that Claimant had an essentially normal neurological examination of his lower extremities. *Id.*

Dr. Rashkin was asked whether his opinion regarding causation would be different if he knew that Claimant had prior injuries to his neck and low back:

> Q: Doctor, would your opinion on causation be different if it was established that the claimant had had prior injuries to his neck and low back for which he had received treatment long before he saw you, long before the accident upon which this claim is based?
>
> A: No, not at all. I can't apportion what part of the symptoms are due to the crane that fell on his head, but my opinion would be essentially the same. If he had previous injuries, then the crane -- the forklift/crane that fell on his head that knocked him unconscious probably aggravated a previous condition, if he had previous injuries.

Id. at 34. He acknowledged that he did not know anything about previous injuries prior to the time he saw Claimant. *Id.*

5. Deposition Testimony of Dr. Conrad P. Weller

Dr. Weller gave a deposition on April 11, 2005.[6] CX 2. He testified that he is licensed to practice medicine in Florida and certified in psychiatry by the American Board of Psychiatry and Neurology.[7] *Id.* at 3. His practice is limited to the field of psychiatry. *Id.* at 4.

Dr. Weller testified that he examined Claimant three times.[8] *Id.* at 5, 22. Claimant told Dr. Weller that he wanted him to perform an examination because he was suffering from headaches, neck pain, low back pain, forgetfulness, and problems sleeping at night. *Id.* Claimant also reported edginess, frustration, and feelings of depression. *Id.*

Dr. Weller testified that he originally examined Claimant on April 6, 2004. *Id.* at 6. He stated that he took a history from Claimant in which Claimant reported that he was injured on March 26, 2003, after being hit with a C-clamp, a large piece of metal, while operating a forklift. *Id.* at 8. Dr. Weller testified that Claimant showed some physical pain. and reported "symptoms of sadness and pessimism most of the time, loss of interest, inability to enjoy things. That's called anhedonia." *Id.* at 11. Claimant also reported irregular nighttime sleep, a reduced energy level, and a depressed appetite. *Id.*

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[6] Dr. Weller's report of the Independent Medical Examination of Claimant he performed on April 6, 2004 is attached to his deposition testimony and marked as Exhibit 2.

[7] Dr. Weller's curriculum vitae is attached to the deposition transcript and marked as Exhibit 1.

[8] Dr. Weller testified incorrectly that the first time he saw Claimant was first on March 28, 2005. CX 2 at 5. He subsequently noted that he had seen Claimant approximately a year earlier, on April 6, 2004 when he performed an Independent Medical Examination of Mr. Ball. *Id.* at 6.

Dr. Weller testified that he performed various tests on Claimant during his examination. *Id.* at 12. He stated that he utilized the Beck scales, a self-reporting clinical evaluation which produces a broad profile of the pattern of complaints. *Id.* Dr. Weller testified that he also administered a Personality Assessment Inventory ("PAI") which checks "some issues about personality structure." *Id.* at 13-14. From these tests, Dr. Weller concluded that Claimant was experiencing "significant social and environmental stress." *Id.*

Dr. Weller diagnosed Claimant with a major depressive disorder, an anxiety disorder, a pain disorder, and chronic pain syndrome. *Id.* The cause of Claimant's depression and anxiety, according to Dr. Weller, was his injury, which "led to chronic pain, inability to work, all kinds of concerns about his own future, and about his present finances." *Id.* at 15. He concluded that "the chronic pain, physical limitations, and their aftermath had precipitated the psychiatric difficulty." *Id.* Dr. Weller noted that Claimant had been functioning well before his accident and that his functioning had been significantly compromised thereafter. *Id.* at 16.

Dr. Weller testified that Claimant's psychiatric condition and occupational functioning are intertwined, such that Claimant's psychiatric condition renders him incapable of performing continuously and uninterruptedly. *Id.* He continued that Claimant's psychiatric condition impairs his concentration significantly. *Id.* at 17. Dr. Weller testified that Claimant's depression and anxiety decrease his energy, stamina, and sleep patterns. *Id.*

At the time of his deposition, Dr. Weller opined that Claimant was not employable because he was not stabilized. *Id.* He stated that at the time of his last examination, March 2005, Claimant had not reached MMI. *Id.* He testified that Claimant was in need of further psychiatric treatment, as well as help with pain management. *Id.* at 18-19. Dr. Weller also noted that Claimant needed antidepressant and anti-anxiety medication. *Id.* at 20.

On cross-examination, Dr. Weller testified that Attorney Yanger referred Claimant to him. *Id.* at 27. Mr. Yanger prepaid $1,400 for Dr. Weller to examine Claimant in April 2004. *Id.* at 28-29. Dr. Weller stated that he believed Mr. Yanger paid him $180 to see Claimant on March 28, 2005. *Id.* at 30. He stated that he has examined approximately a dozen of Mr. Yanger's clients in the five years prior to his deposition. *Id.* at 32.

Dr. Weller testified that he did not place any restrictions on Claimant's driving. *Id.* at 38. Claimant drove to his appointment at Dr. Weller's office, a distance of approximately 10 miles. *Id.* at 36. Dr. Weller did not place any additional restrictions on Claimant's activity after his examination. *Id.* at 37.

Dr. Weller testified that normal MRIs and CAT scans of the brain do not rule out a post-concussion syndrome. *Id.* at 39. He did not find any major post-concussion syndrome in examining Claimant. *Id.* at 40. He stated that Claimant had a normal MRI and a normal CAT scan. *Id.* at 41.

Dr. Weller acknowledged that a patient's social history is important in that it allows a doctor to understand the behavior of an individual, make comparisons, and speculate about

possible prognoses. *Id.* at 42. He testified that he was aware that Claimant used marijuana and cocaine into his 30s, beat up a man with a pool stick, and had prior accidents. *Id.* at 43.

Dr. Weller explained that the PAI test is used as a "second opinion." *Id.* at 44. He testified that Claimant reported having problems in life due to alcohol and drug use. *Id.* at 45. Dr. Weller stated that the PAI takes information provided and produces a correlate, a statistical analysis. *Id.* at 47. He testified that drug use does not necessarily lead to depression. *Id.* at 49.

Dr. Weller stated that the information he received before examining Claimant was from Claimant and Mr. Yanger. *Id.* at 50. He testified that he concluded Claimant was functioning well before his injury and there was no evidence to the contrary. *Id.* at 52. He acknowledged that he had no "independent information" concerning Claimant's day-to-day life. *Id.*

Dr. Weller testified that 95 percent of patients "in workers' compensation" suffer from depression. *Id.* at 57. He acknowledged that he recommended no less than six months of psychiatric treatment for Claimant. *Id.* at 58. He stated that this is a "very conservative and very restrained recommendation." *Id.* at 59.

6. Medical Reports of Dr. Jorge Inga

Dr. Inga's first examination of Claimant occurred on August 4, 2003. CX 3. According to Dr. Inga, Claimant's chief complaint was cervical pain going into the base of the neck and both shoulders. *Id.* at 1. Claimant also complained of sudden hearing loss on the right side and lumbar pain. *Id.* He stated that the symptoms stemmed from injuries he sustained while working on March 26, 2003. *Id.* Claimant reported being hit by the metal arms of the forklift that fell on his head by accident. *Id.* He noted that he was knocked unconscious despite wearing a hard hat. *Id.*

Dr. Inga reviewed an MRI scan of Claimant's lumbar spine taken April 25, 2003. According to Dr. Inga, the MRI scan evidenced "broad base disc bulging at L4-L5 with bilateral neural foramina narrowing." *Id.* An MRI scan of the cervical spine, also conducted April 25, 2003, showed evidence of a small central disc protrusion at C3-C4 and degenerative spondylolytic changes at C6-C7. *Id.* at 2. Dr. Inga stated that an MRI scan of Claimant's brain was "unremarkable." *Id.*

Claimant reported a cracking sensation in the upper cervical region. *Id.* Claimant stated that he had no previous history of his symptoms. He did have surgery on his ear in the 1970s. *Id.*

On physical examination, Dr. Inga found "mild tenderness on palpation of the paraspinal muscles of the mid and low cervical spine." *Id.* at 3. An examination of Claimant's ear canal showed evidence of scarring of the tympanic membranes bilaterally. *Id.* Dr. Inga found that Claimant had complete hearing loss on the right side. *Id.* Dr. Inga opined that Claimant had a small central protrusion at C3-C4, a bulging disc at L4-L5, hearing loss on the right side, and he ruled out trauma to the inner ear. *Id.* at 4.

Dr. Inga concluded that Claimant had a history of symptoms and signs consistent with cervical and lumbar discogenic disease. *Id.* at 5. He opined that Claimant's neurological examination failed to disclose evidence of a focal neurological deficit. Dr. Inga suggested that Claimant undergo a CAT scan of his cervical spine, as well as an ENT consultation for an evaluation of the sudden complete hearing loss on the right side. He opined that Claimant was not at MMI at the time and was temporarily totally disabled. *Id.*

Dr. Inga's second examination of Claimant occurred on September 17, 2003. Claimant continued to complain of cervical pain and a grinding sensation when rotating his neck. *Id.* at 1. Claimant also complained of pain in the lumbar area and hearing loss on the right side. *Id.*

On physical examination Dr. Inga stated that the neurological examination remained unchanged. *Id.* at 1. He reported that Claimant had tenderness on palpation of the paraspinal muscles of the cervical spine with limitation to his range of motion. *Id.*

Dr. Inga read a CAT scan undergone by Claimant, noting evidence of a bulging disc at C4-C5 and changes of cervical spondylosis at C5-C6. *Id.* There was no evidence of a compromise of the neural foramen. *Id.* In the lumbar area, Dr. Inga opined there was evidence of a disc bulging at L4-L5, where Claimant had mild spinal stenosis. Dr. Inga found no clear evidence of a herniated lumbar disc.

Dr. Inga wanted to evaluate Claimant again six weeks after this evaluation. *Id.* at 2. He opined that Claimant was not yet at MMI and remained temporarily totally disabled. *Id.*

Dr. Inga also wrote two letters, dated August 4, 2003 and August 13, 2003. In his August 4, 2003, letter, Dr. Inga stated that Claimant could not return to work until a complete myelogram and CAT scan were conducted. He noted that he was to examine Claimant on September 18, 2003, at which time he would determine Claimant's work status. In his August 13, 2003, letter, Dr. Inga also opined that Claimant remained "temporarily and totally disabled and unable to engage in any type of gainful employment."

Dr. Inga reviewed documents in connection with another report, dated September 25, 2003. He evaluated Claimant's neurological condition to decide if he was a surgical candidate. Dr. Inga reviewed myelograms and CAT scans of Claimant's cervical spine and lumbar spine. In the cervical area, Claimant evidenced cervical spondylosis with narrowing of the ventral subarachnoid space. Based on his review of the radiographic evidence, Dr. Inga opined that Claimant was not a candidate for surgical treatment at the time.

7. Deposition Testimony of Dr. Jay B. Farrior

Dr. Farrior gave a deposition on January 31, 2001. EX 6. On direct examination, he testified that he is licensed to practice medicine in Florida. *Id.* at 3. He stated that he specializes in "otolaryngology specializing in otology, which is disease and surgery of the ear." *Id.* Dr. Farrior stated that he is board-certified. *Id.*

Dr. Farrior acknowledged that he treated Claimant first in October 1999. *Id.* at 4. He testified that at the time, Claimant had a perforated or retracted right ear drum. *Id.* Dr. Farrior noted that Claimant's left ear had a "retraction pocket suggesting poor eustachian tube function." *Id.* He opined that, at the time of the October 1999 examination, Claimant had moderate to severe hearing loss. *Id.* at 5.

Dr. Farrior testified that he examined Claimant again on August 21, 2000. *Id.* at 6. He stated that Claimant's hearing was "a little bit worse" than during the prior examination. *Id.* at 7. Dr. Farrior noted that for high range pitches, Claimant suffered "very bad loss" in both ears. *Id.*

Dr. Farrior testified that Claimant underwent surgery on his ear on October 5, 2000. *Id.* at 8. He explained that "high frequency hearing loss" causes people to have difficulty understanding high pitch noises, such as a wrist watch alarm or car indicator. *Id.* at 9. Dr. Farrior noted that during the October 1999 examination, Claimant had "significant troubles hearing regular conversation." *Id.*

Dr. Farrior opined that "without hearing aids, [Claimant] would have trouble hearing a normal conversation." *Id.* at 10. He noted that, at the time of his testimony, Claimant did not wear hearing aids. *Id.* He stated that Claimant's inner ear, his bone conduction, was "working basically normal." *Id.* at 12.

On cross-examination, Dr. Farrior testified that Claimant, with a hearing aid, could hear virtually within normal range. *Id.* at 14. He stated that he performed surgery on Claimant's left ear on October 28, 1999. *Id.* at 15. He noted that Claimant had a great deal of scar tissue and infection in the ear at the time. *Id.* Dr. Farrior testified that Claimant also had cholesteatoma and perforation of the ear drum. *Id.* at 16. He stated that Claimant had chronic eustachian tube function in both ears, which was part of the reason for performing surgery on each ear. *Id.* He further noted that Claimant had chronic inflammation of the middle ear. *Id.*

Dr. Farrior testified that he operated on Claimant's left ear twice, both times enlarging the ear canal, rebuilding the ear canal and ear drum, and inserting a ventilating tube. *Id.* at 17-18. He stated that after Claimant's most recent ear surgery, he felt he could hear better. *Id.* at 19.

On redirect examination, Dr. Farrior explained that Claimant's main hearing problem is with his middle ear. *Id.* at 21. He stated that Claimant had so much scarring that the little bones in his ear could not "vibrate to transmit sound from the outside to the inside." *Id.* He testified that the type of hearing loss Claimant had usually was conducive to hearing aids. *Id.*

IV. DISCUSSION

Injury Arising Out of and In the Course of Employment.

Claimant bases his claim for disability and medical benefits under the Act solely on an accident that occurred on March 26, 2003. *See, e.g.,* Claimant's Post Trial Memorandum of Issues, Facts and Conclusions ("Cl. Br.") at 1-2. Claimant alleges that he sustained neck and back injuries, mental disorders, headaches, and hearing loss as a result of the accident. The

evidence Claimant offers in support of this claim consists of the testimony of himself and Drs. Rashkin, Weller, and Inga. As explained below, I find that Claimant's employment with Employer caused his headaches, as well as neck and back problems, but not his alleged mental problems or hearing loss.

According to Section 20(a) of the LHWCA, "[i]n any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary . . . [t]hat the claim comes within the provisions of this Act." 33 U.S.C. § 920(a). "Section 20(a) . . . provides claimant with a presumption that his injury is causally related to his employment if claimant establishes a harm and that working conditions existed or an accident occurred which could have caused, aggravated or accelerated the harm." *Uglesich v. Stevedoring Servs. of Am.*, 24 BRBS 180, 182 (1991) *citing Blake v. Bethlehem Steel Corp.*, 21 BRBS 49 (1988). However, before availing himself of the Section 20(a) presumptions, a Claimant must establish that the employment events claimed to be the cause of the harm in fact occurred. *Murphy v. SCA/Shayne Bros.*, 7 BRBS 309, 312 (1977); s*ee also Sewell v. Noncommissioned Officers' Open Mess*, 32 BRBS 127, 128 (1997), *reconsideration denied en banc*, 32 BRBS 134 (1998); *Stevens v. Tacoma Boatbuilding Co.*, 23 BRBS 191 (1990); *Perry v. Carolina Shipping Co.*, 20 BRBS 90 (1987). According to the United States Supreme Court, a *prima facie* case must at least allege an injury that arose in the course of employment as well as out of employment. *U.S. Industries/Federal Sheet Metal, Inc. v. Director, OWCP*, 455 U.S. 608, 615 (1982).

If a *prima facie* case is established, the presumption is created under Section 20(a) that the employee's injury or death arose out of employment. To rebut the presumption, the party opposing entitlement must present substantial evidence proving the absence of or severing the connection between such harm and employment or working conditions. *Parsons Corp. of California v. Director, OWCP*, 619 F.2d 38 (9th Cir. 1980); *Butler v. District Parking Management Co.*, 363 F.2d 682 (D.C. Cir. 1966); *Ranks v. Bath Iron Works Corp.*, 22 BRBS 301, 305 (1989). "Substantial evidence" means evidence that reasonable minds might accept as adequate to support a conclusion. *Noble Drilling v. Drake*, 795 F.2d 478 (5th Cir. 1986); *E & L Transport Co. v. N.L.R.B*, 85 F.3d 1258 (7th Cir. 1996).

The first prong that triggers the presumption set forth under Section 20(a) is whether the Claimant actually suffered harm or pain. Employer paid temporary total disability benefits to Claimant from March 27, 2003 to June 2, 2003 and August 4, 2003 to September 14, 2003. EX 68. Moreover, treatment records and medical reports in the instant record reflect that Claimant suffered headaches, hearing loss, and a spinal injury following his March 26, 2003 accident, and he has been diagnosed by Dr. Weller as suffering from depression, anxiety, and chronic pain syndrome. As such, it has been established that Claimant has suffered actual harm or pain.

The second condition that must be satisfied is that working conditions must have existed or an accident must have occurred which could have caused, aggravated or accelerated the harm. In this case, to avail himself of the Section 20(a) presumption, Claimant must show that his accident could have caused, aggravated or accelerated his alleged injuries.

Employer does not dispute that Claimant had an accident on March 26, 2003. Employer's Post-Trial Brief ("Emp. Br.") at 2. Claimant was hit in the head by a sea clamp that weighs, according to Claimant, approximately 3,000 pounds. Tr. 23. He stated that it normally takes two men to load the sea clamp onto a pallet. Tr. 24. He also noted that he was knocked unconscious by the force of the sea clamp. Tr. 21-22. Employer has not disputed or provided evidence contrary to these statements by Claimant.

Due to the size and weight of the sea clamp, as well as the fact that Claimant was knocked unconscious due to his injury, it is conceivable that the accident "could have caused, aggravated or accelerated [Claimant's head and spinal] injuries." 33 U.S.C. § 920(a). With regard to Claimant's spinal injuries, all of the physicians agree that Claimant suffered an injury which affected his spine, and any discrepancies in the physicians' opinions simply involve the length and extent of Claimant's disability. Similarly, treatment records immediately following the accident and thereafter contain various complaints of headaches following the blow to the head suffered by Claimant. Therefore, I find that Claimant is entitled to the presumption set forth in Section 20(a) with regard to his headaches and spinal injuries.

With regard to Claimant's assertion that he suffered a hearing loss while employed by Logistec, the records of Drs. Martinez, Rashkin, Inga, and Farrior note that Claimant was suffering from a hearing loss subsequent to his March 26, 2003 accident. EX 31 at 4; CX 1 at 8; CX 3 at 1. However, the medical evidence also establishes that Claimant had sustained a hearing loss long before his accident. *See, e.g.*, EX 6, EX 31 at 4; CX 1 at 8; CX 3 at 1; EX 6 at 16. For example, the evidence shows, *inter alia*, that prior to March 26, 2003 Claimant was treated for chronic ear infections, suffered from a moderate to severe bilateral hearing loss, wore hearing aids in both ears, had a perforated or retracted right ear drum, a "retraction pocket suggesting poor eustachian tube function" in the left ear, and suffered from cholesteatoma[9] and chronic inflammation of the middle ear. EX 6 at 3-4, 16, Tr. 33-35. Furthermore, there are no objective tests which establish the level of the hearing loss after his accident, and there is thus no objective basis upon which to compare Claimant's hearing capabilities before and after the accident. Finally, there are no medical opinions in the record which attribute Claimant's hearing loss, or any aggravation of his hearing loss, to his work-related accident, *i.e.*, no physician ever stated that Claimant's hearing loss was caused or aggravated in any way by the blow to the top of his head on March 26, 2003, or indeed even whether such a blow could have caused or aggravated a hearing loss. It would thus be pure speculation to attribute any change in the level of Claimant's hearing loss to the blow to the top of his head on March 26, 2003. Since Claimant has not shown that his accident could have caused, aggravated or accelerated his hearing loss, I find that he is not entitled to the presumption set forth in Section 20(a) regarding his hearing loss.

The record also does not support invocation of the Section 20(a) presumption with respect to Claimant's assertion that he suffers from a mental disorder as a result of his accident. First, I note that none of the medical records reflecting Claimant's treatment for nearly a year after his March 26, 2003 accident mention anything whatsoever about depression, anxiety, or any

[9] "Cholesteatoma" is defined as "A tumorlike mass of keratinizing squamous epithelium and cholesterol, usually occurring in the middle ear and mastoid region. Also called *pearl tumor*." *See* http://dictionary.reference.com/browse/cholesteatoma last visited July 7, 2006.

other mental problems.[10] Indeed, the first time Claimant was ever seen for an alleged mental condition was over a year after his accident when he was examined by Dr. Weller on April 6, 2004 at the request of his attorney. CX 2, Exhibit 2. There is thus no temporal correlation between the accident and Claimant's subsequently diagnosed mental disorders. Second, I note that Dr. Weller has a long-standing relationship with Claimant's counsel giving rise to an inference of bias favoring patients, such as Mr. Ball, who are referred to him by Mr. Yanger.[11] Third, I also note that Dr. Weller appears predisposed to find that virtually *every* patient he examines under the circumstances presented here suffers from depression or another mental disorder in light of his testimony that, in his opinion, 95 percent of all patients "in workers' compensation" cases suffer from depression.[12] CX 2 at 57. Finally, Dr. Weller's conclusions with respect to Claimant's mental condition in this case are based principally on Mr. Ball's own description of his symptoms and changed circumstances since the time of the accident. After observing Claimant's demeanor, listening to his testimony during the formal hearing, and reviewing the entire record, I find that Claimant is simply not a credible witness. His complaints of physical limitations and continuing pain long after he was released for work by Drs. Martinez and Newman were belied in large part by his demeanor and observable actions during the course of the hearing.[13] Furthermore, none of the reports from the multiple objective tests administered by physicians who examined Claimant after the accident support the level of disability displayed by Claimant at the time of the hearing. Given Claimant's lack of credibility, Dr. Weller's reliance on Claimant's description of his symptoms and circumstances to formulate his opinions in this case further diminishes the value of his conclusions. I thus find that Claimant has failed to establish a *prima facie* claim that his mental disorders were caused by his work-related accident, and he is therefore not entitled to the Section 20(a) presumption with respect to that claim.[14]

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[10] The first reference to any such condition is in Dr. Rashkin's February 24, 2004 report of examination in which he states that Claimant is suffering from anxiety due to the level of his discomfort and financial situation. CX 1, Ex. 2 at 4.

[11] Dr. Weller testified that he had seen a dozen or so of Claimant's counsel's clients over the last five years, and that his expenses relating to those examinations were paid for by Claimant's counsel. CX 2 at 31. His evaluations cost at least $1,500, he was paid $200 per hour for depositions, and he could not identify any of the clients referred to him by counsel as not having been diagnosed with depression. *Id.* at 34.

[12] Dr. Weller similarly testified that he could predict that he would diagnose depression in 19 out of the next 20 patients he saw for the purpose of conducting independent medical evaluations. CX 2 at 58.

[13] Claimant appeared at the formal hearing with a cane, his movements throughout the hearing were extremely slow and guarded, and his actions appeared to me to be grossly exaggerated.

[14] Even if I were to assume *arguendo* that the Section 20(a) presumption applied with respect to Mr. Ball's mental disorder claim, my ultimate conclusion regarding that claim would be the same since there is substantial evidence in the record which establishes the absence of any connection between Claimant's alleged depression, anxiety, and chronic pain disorder and the March 26, 2003 injuries he sustained. For example, Drs. Martinez and Newman made it clear that, *inter alia*: Mr. Ball's degenerative changes to the spine existed long before his accident while working for Logistec; his accident only temporarily aggravated that condition; he suffered no further impairment after June 2003; and Claimant's complaints of pain and stiffness were consistent with his symptomatic degenerative arthritis. *See* discussion of medical evidence under "Nature and Extent" of disability *infra* at 18-19. Since Dr. Weller determined that Claimant's psychiatric problems were precipitated by his "chronic pain, physical limitations, and their aftermath," CX 2 at 16, and the pain and limitations experienced by Mr. Ball were, according to the reasoned opinion of Dr. Martinez, caused by his pre-existing degenerative arthritis, the mental disorders claimed by Mr. Ball were not caused by any harm he suffered on March 26, 2003.

If a *prima facie* case is established with respect to one or more injuries, the presumption is created under Section 20(a) that the employee's injury or death arose out of employment. To rebut the presumption, the party opposing entitlement must present substantial evidence proving the absence of or severing the connection between such harm and employment or working conditions. *Parsons Corp. of California v. Director, OWCP*, 619 F.2d 38 (9th Cir. 1980); *Butler v. District Parking Management Co.*, 363 F.2d 682 (D.C. Cir. 1966); *Ranks v. Bath Iron Works Corp.*, 22 BRBS 301, 305 (1989). "Substantial evidence" means evidence that reasonable minds might accept as adequate to support a conclusion. *Noble Drilling v. Drake*, 795 F.2d 478 (5th Cir. 1986); *E & L Transport Co. v. N.L.R.B*, 85 F.3d 1258 (7th Cir. 1996).

As noted above, all of the physicians who examined Claimant agree that he suffered an injury which affected his head, neck and back and disagree only with respect to the length and extent of Claimant's disability. Since Employer has presented no evidence to rebut the Section 20(a) presumption with respect to these injuries, I find that Claimant has established that his headaches, as well as his neck and back injuries, arose out of his employment with Logistec.

Nature and Extent

Having established one or more injuries, the burden now rests with Claimant to prove the nature and extent of his disability. *Trask v. Lockheed Shipbuilding Constr. Co.*, 17 BRBS 56, 59 (1985). A claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical improvement ("MMI"). *Id.* at 60. Any disability before reaching MMI would thus be temporary in nature.

The date of MMI is defined as the date on which the employee has received the maximum benefit of medical treatment such that his condition will not improve. The date on which a claimant's condition has become permanent is primarily a medical determination. *Mason v. Bender Welding & Mach. Co.*, 16 BRBS 307, 309 (1984). The date of maximum medical improvement is a question of fact based upon the medical evidence of record regardless of economic or vocational consideration. *La. Ins. Guaranty Ass'n v. Abbott*, 40 F.3d 122, 29 BRBS 22 (5th Cir. 1994); *Ballesteros v. Willamette Western Corp.*, 20 BRBS 184, 186 (1988); *Williams v. Gen. Dynamics Corp.*, 10 BRBS 915 (1979).

The question of extent of disability is an economic as well as medical concept. *Quick v. Martin*, 397 F.2d 644 (D.C. Cir. 1968); *Eastern S.S. Lines v. Monahan*, 110 F.2d 840 (1st Cir. 1940). The claimant bears the initial burden of showing that a work-related injury prevents him from performing his former job. *Kalama Services, Inc. v. Director, Office of Workers' Compensation Programs*, 354 F.3d 1085, 1090 (9th Cir. 2004) *citing Edwards v. Director, Office of Workers Compensation Programs*, 999 F.2d 1374, 1375 (9th Cir. 2004). A claimant who shows he is unable to return to his former employment due to his work related injury establishes a *prima facie* case of disability. The burden then shifts to the employer to show the existence of suitable alternative employment. *P & M Crane Co. v. Hayes*, 930 F.2d 424, 420, 24 BRBS 116 (5th Cir. 1991); *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038, 14 BRBS 1566 (5th Cir. 1981). Furthermore, a claimant who establishes an inability to return to his usual employment is entitled to an award of total disability compensation until the date on which the employer demonstrates the availability of suitable alternative employment. *Rinaldi v. Gen.*

Dynamics Corp., 25 BRBS 128 (1991). If the employer demonstrates the availability of realistic job opportunities, the employee's disability is partial, not total. *Southern v. Farmer's Export Co.*, 17 BRBS 24 (1985). Issues relating to nature and extent do not benefit from the Section 20(a) presumption. The burden is upon Claimant to demonstrate continuing disability, whether temporary or permanent, as a result of his accident.

Employer paid Claimant temporary total disability benefits from March 27, 2003 to June 2, 2003 and then from August 4, 2003 to September 14, 2003. EX 68. Therefore, the question is whether Claimant was unable to return to his usual employment with Employer between June 2, 2003 and August 4, 2003 or subsequent to September 14, 2003. Based on the evidence of record, I have found that Claimant has shown that he suffered from headaches and neck and back injuries as a result of his March 26, 2003 accident, but not any of the other alleged injuries. Therefore, if Claimant can prove that he was unable to work in his usual employment because of his headaches and/or spinal injuries between June 2, 2003 and August 4, 2003, or after September 14, 2003, he would be entitled to an award of total disability compensation until the date on which Employer demonstrates the availability of suitable alternative employment. *Rinaldi*, 25 BRBS 128.

For the reasons explained below, I find that Claimant has failed to establish that he was unable to return to his former employment due to his work related injury for either of the above specified periods of time. Claimant's primary job was as a forklift driver handling incoming fresh fruit. Tr. 39. On the day he was injured, he was operating an electronic forklift that had an automatic transmission and power steering. Tr. 39-40. His duties as a forklift driver included some physical labor, such as stacking boxes. Tr. 46**.** The medical opinion evidence of record, when viewed as a whole, establishes that Claimant could have returned to his former employment in June 2003.

Dr. Martinez was Claimant's treating physician after the accident. When he first examined Claimant on April 23, 2003, he concluded that Claimant suffered from tenderness over the C4-C5 vertebrae and mild muscle spasm. EX 25 at 3. As a result, he put Claimant on restricted physical activity, recommending no jumping or bouncing exercises and no lifting of greater than 20 pounds from a bent position. *Id.* After conducting another examination of Claimant on May 12, 2003 and reviewing an MRI, Dr. Martinez concluded that Claimant's cervical spine demonstrated multiple level disk degeneration and bulging with protrusion at C3-4 which he determined appeared to be pre-existing degenerative changes. EX 27 at 1. An MRI of Claimant's lumbar spine similarly demonstrated multiple level degenerative changes at L4-5 with a bulging disk. *Id.* Dr. Martinez opined that Claimant had probable degenerative arthritis of the cervical, thoracic, and lumbar spine. *Id.* at 2. After his third examination of Claimant on June 11, 2003, Dr. Martinez concluded that Mr. Ball could return to regular, full-time work with no restrictions. EX 28 at 1. On that same date, he responded to an inquiry from Claimant's nurse case manager, Margaret Yasick, that a formal pain management program was not indicated with respect to Mr. Ball's injury. EX 30. He later testified that Claimant had reached MMI as of that date with no evidence of permanent injury. EX 74 at 9-10. He also testified that MRI scans of Claimant's lumbar spine indicated that "these changes were degenerative and would take years to develop." *Id.* at 10. After reviewing medical records of Drs. Inga, Newman, and Rashkin, and examining Claimant for a fourth time on June 15, 2004, Dr. Martinez concluded

that Claimant had full range of motion of the neck and back. EX 31 at 3. He similarly testified during his deposition that Claimant's cervical, thoracic, and lumbar spine examination was normal and revealed full range of motion with no muscle spasms. EX 74 at 10, 12. His neurological examination of Claimant was also normal. *Id.* at 12. Based on these examinations and test results he concluded that Claimant's accident did not permanently aggravate his pre-existing degenerative condition. EX 74 at 14-15. Because his conclusions are based on multiple examinations of Claimant and objective medical evidence, including MRI and CT scans, I find that Dr. Martinez's opinions are well-reasoned and documented and entitled to substantial evidentiary weight.

Dr. Newman's conclusions with respect to Mr. Ball are similar to those reached by Dr. Martinez. Dr. Newman conducted several MRI examinations of Claimant's lumbar spine and cervical spine. EX 34; EX 35; EX 37. He concluded that the MRIs showed some degenerative changes but were otherwise unremarkable. EX 37 at 1. He similarly testified during his deposition that the MRI scans of Claimant's cervical and lumber spines demonstrated degenerative changes consistent with Claimant's age, but not significant abnormalities. EX 75 at 7-8. An EEG performed on April 29, 2003 by Dr. Newman to evaluate Claimant's headaches revealed no abnormalities. EX 36, EX 37. Dr. Newman conducted a follow-up evaluation of Claimant on June 2, 2003 and concluded, based on CT, MRI, and EEG results, that Claimant had reached MMI with no evidence of any permanent impairment and could resume normal work without any specific restrictions. EX 39. On that same date, he responded to an inquiry from Claimant's nurse case manager, Margaret Yasick, that a formal pain management program was not indicated with respect to Mr. Ball's injury. EX 41. Dr. Newman's conclusions, like those of Dr. Martinez, are based on physical examinations of Claimant and on objective medical evidence, and his diagnoses are consistent with, and supported by, Dr. Martinez's conclusions. Therefore, I find his opinions are well-reasoned and documented and afford them significant evidentiary weight.

Dr. Tresser noted in a report dated October 21, 2003 that he had been scheduled to perform a "second opinion evaluation" of Claimant, but that Mr. Ball failed to appear for his appointment. EX 43. He reviewed MRI scans and x-rays from August 12, 2003 and opined that they showed changes in the cervical spine with spondylosis at C5-6 and a superimposed central bulge at C5-6, which did not appear to be surgical in nature. *Id.* He stated that the bulging disc appeared to be "entirely degenerative in origin consistent with a mid 50-year-old gentleman." *Id.* He opined that Claimant did not have a permanent injury. *Id.* While Dr. Tresser did not comment on work restrictions, his opinion is consistent with those of Drs. Martinez and Newman in that he stated that any injury to Claimant's back was degenerative and that he does not have a permanent injury. Also, his opinion is credible in that he bases his conclusions on objective medical evidence. I thus accord it substantial weight.

As noted previously, Dr. Rashkin examined Claimant only once at the request of his attorney. For the reasons described below, I find his medical opinions are not well reasoned and entitled to less weight than the better-reasoned opinions of Drs. Martinez, Newman, and Tresser.

Dr. Rashkin examined Claimant on February 24, 2004, and his report of that examination reflects impressions of chronic neck, right shoulder, and lower back pain secondary to herniated

discs and disc disease. CX 1, Ex. 2 at 3. Although his findings of disc herniation and disease are supported by the MRI's he reviewed, Dr. Rashkin's report did not associate these conditions with Claimant's accident on March 26, 2003, nor did he impose any work-related restrictions on Claimant as a result of the examination.[15] CX 1 at 30. During his deposition, Dr. Rashkin testified that Claimant's chronic neck and back pain was due to disc disease, but he was equivocal when asked about its origin. CX 1 at 11, 13. He first testified that he did not know whether Claimant's disc disease was a preexisting condition, but he then stated that he believed it was not a preexisting condition. *Id.* at 11-12. Dr. Rashkin further testified that even if Claimant did have a preexisting condition, the blow to the head he suffered on March 26, 2003 aggravated that condition. *Id.* at 12. He also testified that Claimant was temporarily, totally disabled and should not be working. *Id.* at 17. According to Dr. Rashkin, Claimant could not perform any work, whether it was classified as heavy, medium, light, or sedentary. *Id.* at 17-18.

There are several reasons why I accord Dr. Rashkin's opinions regarding the cause and extent of Claimant's impairment less weight than the opinions of other physicians in the record. First, the opinions of Dr. Rashkin, a board-certified anesthesiologist, CX 1, Ex. 1, regarding Claimant's impairment are expressly contradicted by the opinions of Drs. Martinez, Newman, and Tresser, all of whom are board-certified neurologists.[16] EX 32, EX 42, EX 44. All three neurologists concluded that Claimant's herniated discs and disc disease were pre-existing conditions which were neither caused nor permanently aggravated by his March 26, 2003 accident. In contrast, Dr. Rashkin concluded without explanation that the various degenerative changes revealed by diagnostic testing did not exist prior to Claimant's March 26, 2004 accident. Given the fact that the essence of Claimant's complaints are primarily *neurological* in nature, it is reasonable to accord more weight to the opinions of the three board-certified neurologists over that of a single board-certified anesthesiologist. Second, Drs. Martinez and Newman each treated Claimant on multiple occasions at his own counsel's request, and there is nothing in the record to suggest that either physician has any affiliation with, or bias in favor of, Employer or its counsel. In contrast, Claimant saw Dr. Rashkin only once, and was referred to Dr. Rashkin by his present counsel after Mr. Ball discharged his original attorney once Dr. Martinez concluded that he could return to work. Given the fact that Drs. Martinez and Newman are both treating physicians, whereas Dr. Rashkin simply performed an independent medical examination for purposes of Mr. Ball's claim, their opinions may be accorded more weight.[17] Furthermore, given the long-term relationship between Mr. Ball's current counsel and Dr. Rashkin, and the timing of Claimant's discharge of his original attorney, there is least an appearance of "doctor shopping" by Claimant for the purpose of obtaining a medical opinion consistent with his own pecuniary needs. Third, the conclusions reached by Dr. Rashkin based on his February 24, 2004

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[15] Dr. Rashkin testified that at the time of his examination, he did not assign any restrictions on activity and acknowledged that the first time he mentioned any restrictions on Claimant's activity was at the deposition. CX 1 at 30.

[16] "Neurology" is defined as "the scientific study of the nervous system especially in respect to its structure, functions, and abnormalities." http://dictionary.reference.com/browse/neurology last visited July 10, 2006. In contrast, "anesthesiology" is defined as "a branch of medical science dealing with anesthesia and anesthetics." http://dictionary.reference.com/browse/anesthesiology last visited July 10, 2006.

[17] *See, e.g., Amos v. Director, OWCP*, 153 F.3d 1051 (9th Cir. 1998) (treating physician's opinion entitled to "special weight" based on, *inter alia*, number of times physician had opportunity to observe and evaluate patient). *But see, e.g., Hite v. Dresser Guiberson Pumping,* 22 BRBS 87, 91 (1989) *citing Todd Shipyards Corp. v. Donovan,* 300 F.2d 741 (5th Cir. 1962) (ALJ not bound to accept opinion or theory of any particular medical examiner).

examination are directly contradicted by the *subsequent* findings of Dr. Martinez who examined Claimant on June 15, 2004. EX 31. Dr. Martinez concluded based on his June 15, 2004 examination that Claimant's complaints of soreness and stiffness in the back of the head, neck and back were consistent with symptomatic degenerative arthritis. *Id.* at 1. During his deposition he testified that the degenerative changes in Claimant's spine "would take years to develop." EX 74 at 10. He further testified that, although Claimant's accident could have temporarily aggravated his pre-existing condition, Claimant did not suffer any permanent aggravation of his degenerative arthritis. *Id.* at 15. Indeed, Dr. Martinez, like Dr. Newman, concluded that Claimant had no impairment from any cause and was fully capable of unrestricted work by early June 2003. EX 28, EX 37. For all these reasons, I find that Dr. Rashkin's opinions regarding the cause and extent of Claimant's impairment are outweighed by the better-reasoned opinions of Drs. Martinez, Newman, and Tresser.

The only remaining medical opinions of record are those of Dr. Inga. In his August 4, 2003 and September 17, 2003 medical opinions, Dr. Inga concluded that Claimant had not reached MMI and was temporarily totally disabled. CX 3. Dr. Inga cited MRI scans and CAT scans of Claimant's back as evidence of small central protrusion at C3-C4 and a bulging disc at L4-L5. *Id.* He gave no opinion regarding whether Claimant's cervical and lumbar discogenic disease was caused or aggravated by his March 26, 2003 accident nor did he give any explanation for his conclusion that Claimant had not reached MMI. Similarly, Dr. Inga did not cite any findings, clinical or otherwise, which would support his conclusion that Claimant was temporarily totally disabled. Given the lack of any rationale for his conclusions, other than Claimant's self-serving complaints of persistent disabling pain, I find that Dr. Inga's opinions are entitled to little weight.

Based on the foregoing, I find that Claimant reached MMI with respect to his headaches and spinal injuries no later than June 11, 2003, by which time both Drs. Martinez and Newman had concluded that he displayed no signs of impairment from any cause and could therefore return to work without restrictions. EX 28, EX 39. I further find that Claimant has failed to prove by a preponderance of the evidence that he suffered any disability after June 11, 2003 as a result of his March 26, 2003 accident, whether permanent or temporary, partial or total.

Medical Expenses

Claimant is seeking reimbursement for expenses relating to medical services provided by Drs. Weller and Rashkin, as well as payment of continuing medical expenses for injuries sustained at the time of his March 26, 2003 accident. For the reasons that follow, I find that Claimant has failed to prove entitlement to any additional medical payments.

With respect to medical expenses associated with the services already provided by Drs. Weller and Rashkin, Section 7(b) of the Act provides, in relevant part:

> The employee shall have the right to choose an attending physician . . . The Secretary shall actively supervise the medical care rendered to injured employees, . . . shall have the authority to determine the necessity, character, and sufficiency of any medical aid furnished or to be furnished, and may, on [her] own initiative

> or at the request of the employer, order a change of physicians or hospitals when in [her] judgment such change is desirable or necessary in the interest of the employee . . . .

33. U.S.C. § 907(b). The regulations implementing Section 7(b) provide in relevant part:

> (a) Whenever the employee has made his initial, free choice of an attending physician, *he may not thereafter change physicians without the prior written consent of the employer (or carrier) or the district director*. Such consent shall be given in cases where an employee's initial choice was not of a specialist whose services are necessary for, and appropriate to, the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change.
>
> (b) The district director . . . may order a change of physicians or hospitals when such a change is found to be necessary or desirable . . . .
>
> 20 C.F.R. § 702.406(a), (b) (italics added).

Claimant exercised his initial free choice of an attending physician by selecting Dr. Martinez. EX 61. There is nothing in the record establishing that Claimant subsequently obtained the written consent of Employer or the district director before seeing Drs. Weller and Rashkin. Indeed, Claimant testified that he never sought permission from either the Department of Labor or Employer before seeing these physicians, and Employer expressly contested Claimant's right to seek evaluation or treatment by either Dr. Weller or Dr. Rashkin after it learned that Claimant had been referred to these physicians by his newly retained counsel. Tr. 43, EX 61-63. Furthermore, the district director concluded after an informal conference with the parties that:

> The evaluation/treatment with Dr. Rashkin and Dr. Weller is unauthorized as a claimant's attorney can not direct the medical care in a case. The carrier has not denied Mr. Ball access to Dr. Martinez, his treating physician, and Mr. Ball is authorized to return to Dr. Martinez for treatment. Of course, the claimant can share Dr. Rashkin's and Dr. Weller's opinions with Dr. Martinez for his consideration.

EX 64 at 2. Claimant is thus not entitled to reimbursement for the costs of any services provided by Drs. Weller and Rashkin..

With respect to the payment of any future medical expenses, as noted above, Drs. Martinez and Newman concluded that Claimant was fully recovered as of June 2003 from the injuries sustained by him on March 26, 2003. The medical evidence further establishes that any impairment thereafter, if it exists, is a result of Claimant's pre-existing degenerative disease of the spine which was neither caused nor permanently aggravated by his work-related accident. Claimant has thus failed to establish entitlement to continuing medical expenses.

ORDER

It is ordered that the claim of James R. Ball for disability compensation and medical benefits under the Act be and hereby is DENIED.

A

STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.